



**Please indicate if any of the following apply to you:**

**(P = Past C = Current)**

<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Headaches / Migraines	<input type="checkbox"/> Joint Dislocation
<input type="checkbox"/> High / Low Blood Pressure	<input type="checkbox"/> Dizziness / Fainting	<input type="checkbox"/> Joint Reconstruction
<input type="checkbox"/> Stroke or Aneurysm	<input type="checkbox"/> Nausea	<input type="checkbox"/> Bone Fracture
<input type="checkbox"/> Pace Maker	<input type="checkbox"/> Spinal Injury	<input type="checkbox"/> Arthritis
<input type="checkbox"/> other Heart condition	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Epilepsy / other seizures	<input type="checkbox"/> Implants
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> other Neurological condition	<input type="checkbox"/> Transplants
<input type="checkbox"/> other Circulatory condition	<input type="checkbox"/> Irritable Bowel / Colitis	<input type="checkbox"/> Skin condition
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Digestive condition	<input type="checkbox"/> Contagious condition
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Asthma	<input type="checkbox"/> Cancer
<input type="checkbox"/> other Urinary condition	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> <b>are you pregnant?</b>	<input type="checkbox"/> other Respiratory condition	<input type="checkbox"/> HIV

**WHAT AREA(S) OF YOUR BODY IS/ARE BEING TREATED:** \_\_\_\_\_

**Recent treatment: (P = Past C = Current, does not have to be related to this visit)**

Physiotherapy  Massage Therapy  Chiropractor  Naturopath  Other ( \_\_\_\_\_ )

Please list any Medications you presently take: \_\_\_\_\_

Known Allergies (including medications, foods, seasonal, oils and lotions, latex, etc.):

Past surgeries, illnesses, accidents / relevant medical history: \_\_\_\_\_

**Current Condition**

Please describe your current condition & symptoms: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_

How did it start? \_\_\_\_\_

What aggravates it? \_\_\_\_\_

What relieves it? \_\_\_\_\_

Please indicate on the diagram the nature of your symptoms, using the symbols indicated:

Aching	O O
Stabbing	X X X
Shooting	→ →
Burning	## #
Numbness or Tingling	≈ ≈

Other Comments: \_\_\_\_\_